Reminder: Unlisted Procedure, Service or Supply Codes

Providers should always bill a defined procedure, service or supply code when one is available. If a defined code is not available, services can be billed using the unlisted procedure, service or supply code (codes ending in "XXX99"). However, the claim must (1) be submitted on paper (until the time we are able to accept electronically) with (2) the office and/or operative notes (medical notes) and (3) include a written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes.

When a claim is received with a service line for an unlisted code, and the claim does not have both a written description of the service clearly visible and medical notes, the service line is denied as "*Plan Procedures Not Followed*" with a claim adjustment reason code of CO95. The provider is liable for this denial. This service cannot be billed to the member (even with a secured waiver) and cannot be appealed.

A provider can submit a request for review within a reasonable time, not to exceed 60 calendar days from the original date of processing with the CO95 denial reason. Review requests submitted beyond 60 days from the original processing with the CO95 denial will not be accepted.

To request a review, use one of the following methods:

- Resubmit a corrected paper claim including a copy of the claim, a written description of the service clearly visible and medical notes
- Email: utilizationmanagement@bcbsvt.com subject line: Unlisted Code Review
- Fax: (866) 387-7914 Attn: Utilization Management; Unlisted Code Review
- Mailing: BCBSVT, Attn: Utilization Management, Unlisted Code Review, PO BOX 186, Montpelier, VT 05601

Regardless of the method of submission, the request must include a (1) copy of the claim, or the Blue Cross VT claim number, with the (2) office and/or operative notes (medical notes) and include a (3) written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes.

Note: The resubmission must include ALL required information again, even if parts were previously submitted.

Note: if the review results in a denial and you are not in agreement with the decision rendered, the next step is to appeal. See details in Section 6 Member Liabilities "Complaint and Grievance Process". In our on-line Provider Handbook.